NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 25, 2004

RE: MDR Tracking #: M2-05-0136-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an orthopedic surgeon reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Clinical records of ___
- Clinical records of ___ of ___
- Clinical records of ___

Submitted by Respondent:

- Non-authorization recommendation dated 9/2/04
- Reconsideration decision, non-authorization dated 9/9/04
- Peer review by ___, dated 9/1/03

Clinical History

The claimant has a history of chronic right elbow pain allegedly related to a compensable injury that occurred on or about ___. The claimant was employed as a seamstress and history indicates a repetitive use injury (RUI). The claimant has undergone extensive treatment for RUI of left and right upper extremities including a left tennis elbow release and treatment for carpal tunnel syndrome.

Requested Service(s)

Right lateral epicondylar release.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally lateral epicondylar release is indicated in the presence of chronic lateral epicondylitis documented by specific physical findings, x-rays, and response to injection. Surgery is generally indicated following exhaustion of usual and customary measures of treatment including but not limited to oral non-steroidal and corticosteroid medications, bracing of forearm and wrist, injections, physical therapy, and activity modification as well as evaluation of job site, specifically identifying ergonomic modifications. There is no documentation of a clear diagnosis of lateral epicondylitis including consistent physical findings of tenderness of the common extensor origin. There is no documentation of x-ray findings. There is no documentation of exhaustion of conservative measures of treatment, specifically that dealing with response to injection. The documentation does not support the medical necessity of surgical intervention in this clinical setting. I strongly recommend continued clinical evaluation and consideration of alterations in job site to prevent recurrent RUI.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744

Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 25th day of October 2004.